



**Welcome to  
CDE Exam Boot Camp 8**

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## Outline from CDE Exam Handbook

**I. Assessment of Diabetes and Prediabetes (60)**

**A. Assess Learning/Self-Care Behaviors (20)**

1. Goals and learning needs
2. Learning readiness (attitudes, developmental level, perceived learning needs, etc.)
3. Learning style (audio, visual, observational, psychomotor, etc.)
4. Barriers to learning (concrete vs. abstract thinking, literacy and numeracy levels, language, cultural values, religious beliefs, health beliefs, psycho-social and economic issues, family dynamics, etc.)
5. Physical capabilities/limitations (visual acuity, hearing, functional ability, etc.)
6. Readiness to change behavior (confidence in ability to change, value of change, etc.)

**B. Assess Medical/Health/Psychosocial and Economic Status (20)**

1. Diabetes-specific health history (duration, symptoms, complications, adherence to standards of care, treatment, etc.)
2. General health history (family history, allergies, medical history, nutrition history, etc.)
3. Previous and current medication regimen (medication dosage, prescription and nonprescription drugs, herbs, alternative remedies, adverse reactions, etc.)
4. Treatment fears and myths (hypoglycemia, hypoglycemia, needles, weight gain, etc.)
5. Family/caregiver dynamics and social supports
6. Substance use (alcohol, tobacco, caffeine, etc.)
7. Developmental transitions and mental health status (age, life stages, coping ability, adjustment to diagnosis, etc.)
8. Specific barriers to diabetes self-care regimen (cognitive ability, language, cultural, spiritual, psychosocial, physical, economic, etc.)
9. Diabetes-specific physical assessment (injection and blood glucose monitoring sites, blood pressure, weight, height, body mass index, their extremities, acanthosis nigricans, etc.)
10. Laboratory and patient collected data trends (blood glucose, A1C, lipid profile, renal/liver function, etc.)

**B. Teach/Counsel Regarding Principles of Care (50)**

**1. General topics**

- a) Classifications and diagnosis (ADA Clinical Practice Recommendations, AACE, etc.)
- b) Modifiable risk factors (lifestyle behaviors, etc.)
- c) Pathophysiology (auto-immunity, MODY, insulin resistance, fuel metabolism, secondary diabetes, etc.)
- d) Effects and interactions of physical activity, food, medication, and stress
- e) Treatment options (choices, availability, cost, risk/benefit, etc.)
- f) Goals of treatment (blood glucose, A1C, blood pressure, lipids, quality of life, prevention of complications, etc.)
- g) Purpose of laboratory tests (A1C, lipids, kidney and liver function tests, etc.)
- h) Evidence-based diabetes research

**2. Living with diabetes and prediabetes**

- a) Psychosocial adaptation (new diagnosis, complications, coping skills, etc.)
- b) Psychosocial problems (depression, eating disorders, divorce, etc.)
- c) Role/responsibilities of care (patient, family members, team, shared responsibility, etc.)
- d) Decision making/Behavior change skills
- e) Safety (sharps disposal, medical ID, driving, etc.)
- f) Hygiene (dentist/eye/feet, etc.)
- g) Social/financial issues (employment, insurance, disability, discrimination, etc.)

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## Healthy Coping and Behavior Change Objectives

- ▶ Discuss the chronic care model
- ▶ Describe coping and patient assessment
- ▶ List psychosocial, emotional and life barriers to diabetes self-care
- ▶ Discuss strategies to assist patients with individualized coping skills
- ▶ Describe behavior change models and approaches

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## Providing Diabetes Care

- ▶ Setting up successful delivery systems
- ▶ Assessing the unique needs of each individual
- ▶ Supporting diabetes self-care



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## Change the Care System – Focus on Quality of Care delivered

### ▶ Optimal diabetes management requires:

- ▶ organized, systematic approach
- ▶ involvement of a coordinated team of dedicated health care professionals,
- ▶ working in an environment where patient centered high quality care is a priority.



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## Change the Care System – Focus on Quality of Care delivered

### ▶ Evidence based, interdisciplinary teams providing intensive disease management is the strategy that works best.

- ▶ Redesign health care process
- ▶ Electronic health record tools
- ▶ Activating and educating patients
- ▶ Remove financial barriers and reduce cost of care
- ▶ Public policy changes (ie soda tax)
- ▶ Community resources (low cost dental care, farmers market, recreation opportunities).



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## Diabetes Care Concepts - Tenants

- ▶ Keep it patient centered
  - ▶ Consider the individual
  - ▶ Customize standard goals based on assessment
- ▶ Diabetes Across the lifespan
  - ▶ We are getting diabetes earlier and living longer
  - ▶ Promote coordinated care across lifespan
- ▶ Advocacy
  - ▶ Active support and engagement
  - ▶ Address social determinants and underlying causes of health disparities. Let your voice be heard.



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## Major Barriers to Diabetes Care

- ▶ Fragmented health system
- ▶ Lack of electronic information sharing
- ▶ Duplication of services
- ▶ Poorly designed to deliver coordinated care for those with chronic diseases



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## Chronic Care Model - CCM

- ▶ 6 core elements for optimal diabetes care
  - ▶ Proactive (vs reactive) care delivery system.
    - ▶ Planned visits coordinated through a team based approach
  - ▶ Self Management support
  - ▶ Decision support (basing care on evidence based guidelines)
  - ▶ Clinical information systems (registries that provide patient specific and population based support to team)
  - ▶ Community policies and resources to support healthy lifestyles
  - ▶ Health systems that create a culture of quality



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## Redefining Roles and Building Teams

- ▶ Utilizing staff to focus on their strengths and supporting patient self management.
- ▶ Collaborative multi-disciplinary team are best suited to provide diabetes care and support patients in succeeding at self management.



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## Moving on to each Unique Individual



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## How to Improve Chronic Care Model

- ▶ Optimize Provider and Team Behavior
  - ▶ Appropriate and timely intensification of lifestyle if BG not at target
  - ▶ Explicit goal setting
  - ▶ Use evidence based guidelines and clinical information tools
  - ▶ Incorporate care management teams:
    - ▶ Pharmacists, nurses and other providers to improve outcomes
  - ▶ Address literacy and cultural barriers



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## Assess Literacy

- ▶ Numeral
  - ▶ 130 could look same as 310, 013
- ▶ Health
  - ▶ Not sure how to use the health system
  - ▶ Prescriptions, appointments, insurance coverage
- ▶ Functional
  - ▶ Ability to use reading, writing and computation at levels adequate to everyday situations (checkbooks, signs, etc)



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## Reading: Go direct!

- ▶ Is this blood sugar in target?
- ▶ If your blood sugar is xxx, what would you do?
- ▶ Can you read this back to me?
- ▶ Return Demo (please draw it up)



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## Poll question 1

- ▶ Which of the following strategies are best used when someone has low literacy skills?
  - A. speak slowly and clearly
  - B. underline key points on educational materials
  - C. direct the teaching to the support person and encourage reinforcement.
  - D. be concrete and focus on problem solving



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## Teaching Approaches: Low Literacy

- ▶ Be Concrete
- ▶ Word usage (be sensitive!)
- ▶ Identify 1-2 messages
- ▶ Be patient, use teaching aids
- ▶ Small group- problem solving
- ▶ Tech level - video, computer, printed info, "apps"
- ▶ Engage support people



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## When Treatment Goals aren't met

- ▶ Reassess treatment regimen and barriers
  - ▶ Literacy
  - ▶ Diabetes related distress or depression
  - ▶ Poverty
  - ▶ Competing demands including those related to family responsibilities and dynamics
  - ▶ Culturally appropriate education?
  - ▶ Referral to social worker for assistance with insurance coverage
  - ▶ Medication taking behavior and regimen
  - ▶ Other?



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## Psychosocial Assessment

- ▶ Include assessment of the pts psychological and social situation as part of the ongoing medical management of diabetes
- ▶ Psychosocial screening may include:
  - ▶ Attitudes about diabetes
  - ▶ Expectations of medical management and outcomes
  - ▶ Affect/ mood and quality of life
  - ▶ Available resources (financial, social, emotional)
  - ▶ Psychiatric history



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## Assessment Factors:

Stress response and coping strategies are based on:

- ▶ Health beliefs
- ▶ Perceptions
- ▶ Cultural traditions, family system.
- ▶ Social, religious and employment influences
- ▶ Personal factors: attitudes, cognitive factors, literacy, learning styles
- ▶ Psychosocial factors



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Cultural Sensitivity TOOL: Ask Questions in a clear, accepting manner. Ask; **What ...**

- ▶ is important to you?
- ▶ do you think of your diabetes?
- ▶ the best way to communicate with you?
- ▶ are your goals and expectations?
- ▶ are your Personal beliefs and values?
- ▶ are your Cultural and religious practices?
- ▶ How ARE you feeling about all of this?



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## Assessment Factors

- ▶ Developmental age and stage
- ▶ Finances
- ▶ Environment (transportation, location, safety)



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## Assess: Capabilities/limits

- ▶ Physical:
  - ▶ Visual/ hearing/ , psycho-motor, meter, group environment, injection
- ▶ Substance Abuse
  - ▶ Alcohol, tobacco, illicit drugs
- ▶ Support System, who, when, where...)



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## Social Support Assessment Tool

Who helps you?

- ▶ With practical or emotional support ?
- ▶ Who makes it harder?
- ▶ What would you like in support for day-to-day?
- ▶ One thing you could do so you will get the support?
- ▶ What can I do to help you get the support you want?



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## Types of Social Support

(virtual or live)



- |   |   |
|---|---|
| ▶ <b>Emotional support</b> <ul style="list-style-type: none"><li>■ Caring, empathy, love, trust----most important ( perceived )</li></ul>         | ▶ <b>Instrumental support</b> <ul style="list-style-type: none"><li>■ goods/services--- "help" / Apps</li></ul> |
| ▶ <b>Informational support</b> <ul style="list-style-type: none"><li>■ provided during time of stress-problem solving, chat, blog, apps</li></ul> | ▶ <b>Affirmational support</b> <ul style="list-style-type: none"><li>■ affirming acts or statements</li></ul>   |



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## Assess: Learning Style:

▶ Method: read, listen, discuss

- ▶ Sensors: problem solving: demo.
- ▶ Feelers: listening, discussion
- ▶ Thinkers: Facts...lecture



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## Routine Mental Health Screening

- ▶ Depression – affects 20-25% of DM
  - ▶ Increases risk of MI and mortality
  - ▶ High priority to screen and treat for those over 65
  - ▶ Provide a collaborative care approach to treat depression
    - ▶ Diabetes related distress (18-45% of pts)
- ▶ Anxiety
- ▶ Eating disorders
- ▶ Cognitive impairment



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## Poll Question 2

▶ Which of the following statements by a patient reflects they are depressed?

- A. I used to love gardening, now I don't even care if my garden is overrun by weeds.
- B. Yes, I feel sad that I have diabetes.
- C. Some mornings, it's just hard to check my blood sugars.
- D. I am so tired of everyone telling me how to eat!



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## Depression

- ▶ Characterized by depressed mood
- ▶ Loss of interest in activities usually found pleasurable
- ▶ Difficulty concentrating, sleeping, changes in appetite
- ▶ Difficulty in following through with self care behaviors



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## Is Mr. Jones coping well?

- ▶ Mr. Jones is 67 yrs old, Type 2 diabetes for 12 yrs, with unknown A1C. He is widowed and has a low income job (close to lay off), and is teetering on foreclosure of his home.
- ▶ What are some risk factors that may make coping difficult for Mr. Jones?



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## Mr. Jones Assessment

- ▶ He helps take care of his elderly mother, struggles with “feeling blue” and when asked, states he has a few drinks a day....
- ▶ **What are the chances Mr. Jones is depressed?**
- ▶ **Why?**
- ▶ **How could you find out?**
- ▶ **What questions would you ask?**



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## Depression Assessment

### ▶ Depression:

- Over the last 2 weeks, have you felt down, depressed or hopeless?
- Over the last 2 weeks, have you felt little pleasure in doing things?

### ▶ Depression

- ▶ Pt. Health Questionnaire (PHQ-9) in resources page
- ▶ Beck Depression Inventory (BDI)
- ▶ Symptom Checklist (SCL-90)
- ▶ Referral to Mental Health:
- ▶ Refer to therapy (list ready!)
- ▶ Pharmacologic TX  
Anti-depressants: (2-8 weeks to work)



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## Anxiety – Exaggerated response to normal fears

### ▶ Anxiety

- ▶ Symptoms - (must have 5 for over 6mo's)
  - ▶ restlessness,
  - ▶ keyed-up or on-edge
  - ▶ easily fatigued
  - ▶ difficulty concentrating or mind going blank
  - ▶ irritability
  - ▶ muscle tension
  - ▶ sleep disturbances

### Diabetes causes fear –

- ▶ Hypoglycemia
- ▶ Complications
- ▶ Living with chronic condition

### ▶ Impact of Anxiety

- ▶ 1. Counterreg hormones
- ▶ 2. Self-care behavior diminishes



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## Cognitive Impairment

### ▶ People with diabetes more like to have:

- ▶ Dementia (associated with hyperglycemia and other causes)
- ▶ Alzheimer's

### ▶ Treatment:

- ▶ Refer to specialist for assessment
- ▶ Achieve optimal BG control
- ▶ Pharmacist to evaluate drug safety and potential drug interactions
- ▶ Keep physically active



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### Poll Question 3

▶ A 47 year old enters your office and says, “the doctor made me come here. I don’t know why, I just have borderline diabetes”. The pt’s A1c is 8.7%. What is the most appropriate response?



- ▶ A. According to your A1c level, it looks like you have diabetes.
- ▶ B. We don’t use the term “borderline diabetes anymore”
- ▶ C. Let’s just start with carb counting.
- ▶ D. I sense you are feeling frustrated.




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### Adaptation to the Emotional Stress of Chronic Disease

(Kubler-Ross, Rubin RR, WHPolonsky)

Denial	Don't agree, but listen Acknowledge Survival Skills only!
Anger	Indicates: Awareness, Learning Begins Be clear, concise instructs No long WHY answers
Bargaining	ID's w/ others Group classes good Ed: "what" pt. wants to know
Depression & Frustration	Realize permanency of DSC Tx Psycho-social support referral Emphasize + change made
Accept & Adapt	Sense of responsibility for Self-care;

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### Diabetes Related Emotional Distress=DRED

▶ DRED - unique emotional issues directly related to the burdens and worries of living with a chronic disease. (embarrassed, guilty)

- ▶ More than worry: can overlap with depression, anxiety and stress.
- ▶ Normal-to some extent
- ▶ Associated with stress of living with diabetes
- ▶ Express high levels stress and depressive symptoms; but not clinical depression
- ▶ Not rare: linked to poor health outcomes




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## DDS 17: Diabetes Distress Scale

► Yields a total Diabetes Distress Scale score plus 4 sub scores:

- Emotional burden
- Physician related Distress
- Regimen related Distress
- Interpersonal Distress



Begin a conversation with any item rated 3 or more – See Distress Scale in your resources page

- 44.5% of patients reported diabetes distress
- Only 24% of providers asked pts how diabetes affected their life (DAWN Study)



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## Diabetes Distress Scale cont.

1. Feeling that diabetes is taking up too much of my mental and physical energy every day.
2. Feeling that my doctor doesn't know enough about diabetes and diabetes care/ doesn't give me clear enough directions.
3. Feeling angry, scared, and/or depressed ... think about living with diabetes
4. Feeling that I am not testing my blood sugars frequently enough.
5. Feeling that I am often failing with my diabetes routine.
6. Feeling that friends or family are not supportive enough of self-care efforts (planning activities that ..., encourage me to eat the "wrong" foods).
7. Feeling that diabetes controls my life.
8. Not feeling motivated to keep up my diabetes self management.

DDS (17) Scoring

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## Poll question 4

- You assess that your patient with newly diagnosed LADA is struggling with diabetes distress. What is an appropriate intervention?
- A. Encourage them to ask their provider about starting antidepressants.
- B. Set a SMART goal that is very challenging to help move them forward.
- C. Support them in making a small goal
- D. Remind them that alcohol is actually a depressant



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## Strategies to handle DRED:

- ▶ **People w/ DM**
  - ▶ 1 thing at a time
  - ▶ Take it slowly
  - ▶ Speak up to:
    - ▶ Family, PCP,
    - ▶ People that understand.
  - ▶ **Set Appropriate Goals!!!**
  - ▶ **Small, discreet**
- ▶ **HCP providers (you!)**
  - ▶ Handle 1 thing at a time
  - ▶ Take it slowly
- ▶ **Set Appropriate Goals.**  
**Small, discreet**
- ▶ **Be mindful, mundane, careful**  
**about the goal set- do not rush**
- ▶ **Paired testing before/after**  
**(more tangible)**



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## Poll Question 5

- ▶ Which of the following is a SMART Goal?
  - I will lose 5% of my body weight
  - I will eat less sugary foods throughout the week
  - I will monitor my blood sugar on a regular basis
  - I will eat one less bag of chips every day for 1 week.



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## SMART Goals



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## Mental health – Build a Foundation

- ▶ Although the educator might not feel qualified to treat psychological problems, optimizing the patient / educator relationship as a foundation to increase likelihood of acceptance.



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## Key opportunities to Screen for Emotional Health

- ▶ Newly diagnosed
- ▶ Hospitalized
- ▶ When medical status changes (BG no longer controlled with one med)
- ▶ When complications start
- ▶ During regular visits



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## Assess Emotional Health

- ▶ Assess- first meeting and *regularly*.
  - ▶ Use instruments and open ended questions;
  - ▶ ASK! Consider Diabetes Distress vs depression.
- ▶ Encourage Optimism and Resilience:
  - ▶ Hardiness and humor, resources, self confidence!
  - ▶ Develop network of specialists to help YOU for your own self balance and care!
  - ▶ Name 3 NOW! Action Pack for Happiness



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## Referral to Mental Health Specialist

### ▶ Indications

- ▶ Gross disregard for medical regimen
- ▶ Depression
- ▶ Stress related to work-life balance
- ▶ Possibility of self harm
- ▶ Debilitating anxiety and/or depression
- ▶ Eating disorder
- ▶ Poor cognitive functioning that impairs judgement



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## Emotional Well Being

- ▶ Important part of diabetes care and self-management
- ▶ Psychological and Social Problems can impair the ability to self-care and lead to poor health



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## Learning and Behavior Change



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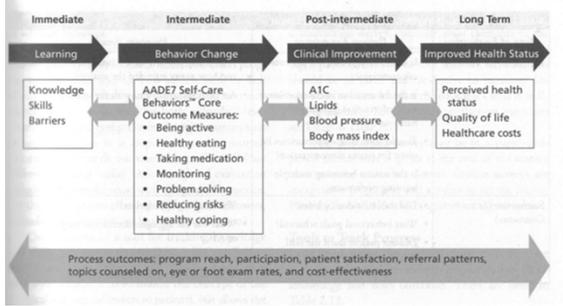
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## AADE 7 Self Care Behaviors



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## Poll Question 6

- ▶ Mary has had diabetes for over 35 years and tells you she knows everything about diabetes. But her doctor insisted she come see you for to check in with her diabetes. What approach recognizes Adult Learning Theory? A1c is 7.3.
- ▶ A. Share with me how you have been managing your diabetes to achieve an A1c of 7.3%.
- ▶ B. Can I please see your log book?
- ▶ C. Please demonstrate how you use your meter
- ▶ D. Are you meeting your targets 80% of the time?



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## Adult Learners



- Self-directed must **feel need** to learn
- **Problem oriented** rather than subject oriented
- Learn better when **own experience** is used
- Prefer **active participation**



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## Facilitating Self-Care - Specific Skills Training

- ▶ Most effective education includes:
  - ▶ demo of skills
  - ▶ practice
  - ▶ direct practical feedback for efforts
- ▶ Didactic: less effective
  - ▶ Provides knowledge without skill
- ▶ Talk Less – Encourage Patient to Participate More
- ▶ *Make the Behavior Real* for that patient



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## Effective Diabetes Self-Management: requires behavior change

- ▶ Barriers to behavior change
  - ▶ Income
  - ▶ Health literacy
  - ▶ Poverty
  - ▶ Health insurance
  - ▶ Competing demands – family, work, other obligations
  - ▶ Diabetes Denial
  - ▶ Diabetes Distress or Depression
  - ▶ Lack of knowledge



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## Barriers to Learning (and behavior change)

### ▶ Her/his perception

Ⓞ Of MY ATTITUDE

Ⓞ And MY WILLINGNESS

to understand ...

“A place of preaching is not a place of meeting...” Mother Theresa



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## Overcoming barriers

- ▶ Identify barriers and help with problem solving
- ▶ Offer patients evidence based hope message
- ▶ Frequent contact – phone, support group, letter, etc.
- ▶ Paired glucose testing (Seeing is believing)
- ▶ Ask pt, “Tell me 1 thing that is driving you crazy about your diabetes
- ▶ Discuss medication beliefs, ask ask ask!
- ▶ To improve outcomes, see pts more often

Bill Polonsky, PhD, CDE



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## “Mindfulness-based Interventions”

- ▶ Avoid compliance model
- ▶ Focus on empowerment and acceptance
- ▶ Mindfulness
  - ▶ “Pay attention-on purpose “
  - ▶ Non-judgmental
  - ▶ In-the-present
  - ▶ Better chance to be present to life and become less reactive to the tides of distraction.
  - ▶ Really HEAR your clients!



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## Poll Question 7

- ▶ Joe is deciding whether or not to start on insulin. His A1c is 9.8%. His mom had diabetes and severe complications due to chronic hyperglycemia. What would best describe application of the Health Belief Model in this situation?
- ▶ A. His level of readiness.
- ▶ B. He is more likely to start insulin if someone he knows is on insulin.
- ▶ C. If he feels empowered to inject insulin.
- ▶ D. The benefit and cost associated with insulin.



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## 1. Health Belief Model

- ▶ Individuals perceived risk and seriousness of illness determines the likelihood of adopting preventive behaviors.
- ▶ The more perceived risk, the more likely to take make necessary changes.
  - ▶ **Influencing factors:**
    - ▶ Level of personal vulnerability about developing illness
    - ▶ How serious person believes the illness is
    - ▶ Efficacy of behavior in preventing or minimizing consequences of illness
    - ▶ Costs or deterrents associated with making changes



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## Expanded Health Belief Model

- ▶ Perceived susceptibility
- ▶ Perceived severity
- ▶ Perceived benefits
- ▶ Perceived barriers
- ▶ **Self-Efficacy**
  - ▶ Level of confidence one has with regard to performing a behavior successfully
- ▶ **Cues to Action**
  - ▶ External stimulus used to activate health behavior (ie TV about the benefits of a glucose meter)



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## 2. Social Cognitive Theory

- ▶ Pts learn from own AND observing “others” behaviors and consequences.
- ▶ Health behavior is a constantly changing and evolving interaction between their environment.
  - ▶ Environment
  - ▶ Behavioral capability
  - ▶ Expectations
  - ▶ Observational Learning
  - ▶ Reinforcement, Self-efficacy



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## Poll Question 8

- ▶ Which of the following statements by the educator best reflects using the empowerment approach?
  - A. We are here to motivate you to get your A1c to target.
  - B. A motivated patient will always be able to achieve an A1c less than 7%.
  - C. What motivates you to improve your A1c?
  - D. If you follow our suggestions, you will achieve your goals.



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## 3. Pt. Empowerment Defined

- ▶ “Helping pt’s discover and develop their inherent capacity to be responsible for their own lives and gain mastery over their diabetes”.
- ▶ Posits:
  - ▶ Choices made by pts (not HCPs) have greatest impact.
  - ▶ Pts are in control of their self-management
  - ▶ The consequences of self-management decisions affect pts most. It is their right and responsibility to be the primary decision makers.



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## Traditional vs Empowerment Based

### Traditional vs Empowerment Based

Table 3.5 Comparison of Traditional and Empowerment-Based DSME and DSMS

Traditional DSME and DSMS	Empowerment-Based DSME and DSMS
Diabetes is a physical illness.	Diabetes is a biopsychosocial illness.
Professional is viewed as teacher and problem solver, and responsible for outcomes.	Patient is viewed as problem solver and self-manager; professional acts as a resource and shares responsibility for outcomes.
Learning needs are usually identified by professional	Problems and learning needs are identified by patient.
Education is curriculum-driven.	Education is patient-centered and consistent with adult learning principals.
Education is primarily didactic.	Patient experiences are used as learning opportunities for problem solving and serve as the core for the curriculum.
Emotional issues are a separate component of the curriculum.	Emotional issues are integrated with clinical content.
Behavioral strategies are used to increase compliance with recommended treatment.	Behavioral strategies are integrated with clinical content and taught to patients to help them change behaviors of their choosing.
Goal of education is compliance/adherence with recommendations.	Goal is to enable patients to make informed choices.
A lack of goal attainment is viewed as a failure by both the patient and the educator.	A lack of goal attainment is viewed as feedback and used to modify goals and action plans.
Behavior changes are externally motivated.	Behavior changes are internally motivated.
Patients is relatively powerless, professional is powerful.	Patient and professional are equally powerful.

Source: Adapted from MM Funnell, RM Anderson, "Patient empowerment: from revolution to evolution," *Treat Strategies Diabetes 3* (2011): 98-105.

**This philosophy is important to know for the exam**



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**Empowerment Based, Self-Directed Behavior Change Protocol**

- ▶ Define problem
  - ▶ What part of living with diabetes is most difficult or unsatisfying for you?
- ▶ Identify feelings
  - ▶ How does the situation make you feel?
- ▶ Identify long term-goal
  - ▶ How would this situation have to change for you to feel better about it?
  - ▶ What barriers will you face?
  - ▶ How important is it for you to address this issue?
  - ▶ What are the costs and benefits of addressing or not addressing this problem?



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**Empowerment Based, Self-Directed Behavior Change Protocol**

- ▶ Identify short-term behavior change experiment
  - ▶ What are some steps that you could take to bring you closer to where you want to be?
  - ▶ Is there on thing that you will do when you leave to improve things for yourself?
- ▶ Implement and evaluate plan
  - ▶ How diet the plan we discussed at your last visit work out?
  - ▶ What did you learn?
  - ▶ What would you do differently next time?
  - ▶ What will you do when you leave here today?



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**Poll Question 9**

- ▶ A patient tells you that they have been thinking about starting an exercise program. Using the trans theoretical model, what stage of change are they in?
  1. Precontemplation
  2. Contemplation
  3. Preparation
  4. Action
  5. Maintenance



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## Transtheoretical Theory

- ▶ **“Readiness” Level determines the approach!**
- ▶ Patients pass through similar stages as they prepare for change (eating better, decreasing drinking)
- ▶ Simplified version of the Stages of Change:
  - ▶ Not ready -no intentions.
  - ▶ Unsure: Ambivalent
  - ▶ Ready: Committed, just needs to know HOW!



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## 4. Transtheoretical Model

■ Stages of Change (Behavior Change Process)

1. **Precontemplation**
2. **Contemplation**
3. **Preparation**
4. **Action**
5. **Maintenance**
6. **Termination** (relapse, recycle)



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## Readiness determines Approach



Precontem- plation:	<u>Contem- plation:</u>	<u>Preparation:</u>	<u>Action/Maint:</u>	<u>Relapse Stuck</u>
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Raise doubt Re: status quo.	Explore + resolve abiva- lence. <u>+ Gains?</u>	<u>Committed to change just needs to know how!</u>	<u>Who-What- Where Praise-Support Plan?</u>	<u>Support- plan- reframe??</u>
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<u>Info?</u>	<u>Prepping?</u>			
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<u>NOPE!</u>	<u>Maybe</u>	<u>OK! I want to!</u>	<u>I'm Doing it x6m</u>	<u>OOOOPS!</u>
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## Gauge it!

Low High

- Get an idea of:
- ~how they feel about the problem,
  - ~their desire to change...
  - ~ would help them succeed...
  - ~ their confidence...
  - ~ what would hold them back...



Low

High

1-----2-----3-----4-----5



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Yellow= Ambivalence-  
concentrate energy here!



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## Explore Ambivalence



- ▶ Ask questions to help the pt. see pros and cons of the issue
  - ▶ Why keep things the same? (disadvantages)
  - ▶ Why change things? (advantages)
  - ▶ {Where does this (your decision) leave you}
- ▶ Summarizing Ambivalence:
  - ▶ Begin with reasons for maintaining the status quo,
  - ▶ give options,
  - ▶ end with positive reasons for making a change.



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## Breaking barriers with Better Approaches~

1. **Have a conversation about their Diabetes Distress, what's really bothering them...**
2. **Set Appropriate Goals with the Patient!!!**  
Small, discreet, WRITTEN.
3. **Be mindful,**
  - ▶ hear the "mundane"-but important,
  - ▶ Be careful about the goal set- do not rush to the "dramatic goal".
  - ▶ Use your expertise to guide in the right direction
  - ▶ Be aware of where you are meeting- giving "more" than the patient?



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## Roll with Resistance

- ▶ Make suggestions...invite client to consider other perspectives.
- ▶ Shift focus ... Reframe...
- ▶ Emphasize personal choice and control "**what change do you feel open to making???**"



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## Recycle/ relapse (being stuck) is part of the cycle!

- ▶ Realistic...
- ▶ Acceptable...
- ▶ To be expected...
- ▶ **To be prepared for...and talked about... "a contingency plan".**
- ▶ Surmountable ( with preparation!)
- ▶ Reframe (+resources)



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## Central Concepts of Motivational Counseling

- ▶ Motivation to change = from the patient
- ▶ Change is the pts' responsibility
- ▶ Direct persuasion is counterproductive!
- ▶ MC style is quiet and eliciting (pts=talking)
- ▶ "Readiness"- product of the interaction



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## Support Self-Confidence

- ▶ Support positive expectations for change...
  - ▶ emphasize personal responsibility,
  - ▶ instill confidence and hope,
  - ▶ increase sense of ability to cope.



*"From what you've told me about your past successes...it really seems like you can do this!"*



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## You are going to do Great!

- ▶ Know how to get to testing site
- ▶ Get a good nights sleep
- ▶ Stand and move around during test
- ▶ Put your hands on your hips.
- ▶ Afterward:
  - ▶ Celebrate – treat yourself
  - ▶ Jot down your impressions
  - ▶ Email us so we can pass it on
  - ▶ When you pass, send us your photo to post!



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## Thank You



► After the exam,  
please let us know  
your impressions!

Beverly's Diabetes Boot Camp online class was comprehensive and detailed. I felt like her class prepared me to take the CDE exam and pass! I want to thank Beverly and her team for their help!

You run a wonderful program and I am so glad I used your materials to study!



Leah Groppo, CDE, Dietitian



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## Thank You



- Questions?
- Email  
[bev@diabetesed.net](mailto:bev@diabetesed.net)
- Web  
[www.diabetesed.net](http://www.diabetesed.net)



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